

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**  
**Department of Health**



**Health Regulation  
& Licensing Administration**

**ASSISTED LIVING RESIDENCE (ALR) LICENSE APPLICATION**

*Please type or print in ink*

**A. RESIDENCE INFORMATION**

Name of Residence Telephone No. Fax No.

Street Address City Zip Code Ward

Mailing Address (If Different from Street Address) City Zip Code

Contact Person for this Application \_\_\_\_\_

Address City/State/Zip Telephone No. E-Mail Address

**B. TYPE OF APPLICATION**

☐ Initial Application      ☐ Renewal Application      ☐ Revised Application

**C. LICENSE & BED FEES**

Please indicate resident capacity here \_\_\_\_\_

- |                                                                                                                                       |              |
|---------------------------------------------------------------------------------------------------------------------------------------|--------------|
| 1. Enter the standard License fee: <u>(\$100.00)</u>                                                                                  | (1) \$ _____ |
| 2. Multiply total number of residents by the per residents fee and enter here: <u>(\$6.00)</u>                                        | (2) \$ _____ |
| 3. Add the amount on lines (1), and (2) and enter here                                                                                | (3) \$ _____ |
| 4. If this is a renewal application mailed less than 90 days prior to license expiration, enter the late fee amount on line (4) here: | (4) \$ _____ |
| 5. Add lines (3) and (4) and enter here. This is your total fee.<br>(Fees should be calculated based on resident capacity)            | (5) \$ _____ |

#### **D. INCREASE IN RESIDENTS CAPACITY**

If this application is only to request an increase in the number of residents (not an initial, renewal, or change of ownership), please complete this section.

Total number of currently licensed ALR residents \_\_\_\_\_

Total number of residents to be: \_\_\_\_\_ Increased

If the whole facility is not licensed as an ALR, identify the location or section where additional ALR residents will be located \_\_\_\_\_

If applying for an increase in the number of residents, multiply the resident fee by the number of residents added and enter total here \$ \_\_\_\_\_

#### **E. APPLICANT/OWNER INFORMATION**

Applicant is a (n)

☐ Individual(s)

☐ Limited Partnership

☐ General Partnership

☐ Corporation

☐ Other (Specify) \_\_\_\_\_

If the applicant is a limited partnership corporation, list the names, document number, and federal identification number registered with the District of Columbia, Division of Corporations within the Department of Consumer and Regulatory Affairs:

\_\_\_\_\_  
(Name of Limited Partnership/Corporation)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Document number)

\_\_\_\_\_  
(Federal Employer Identification Number)

If a limited partnership/corporation, please attach a current copy of your Certificate of Good Standing issued by the Division of Corporations within the Department of Consumer and Regulatory Affairs.

Is the Corporation \_\_\_\_\_ for Profit? \_\_\_\_\_ Not for Profit?

Are the property and building (s) \_\_\_\_\_ owned by the applicant? \_\_\_\_\_ Leased or rented? If leased or rented, who is the property owner(s)?

Name	Address	City/State/Zip	Telephone No.
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Is the residence to be managed by someone other than the applicant? \_\_\_\_ Yes \_\_\_\_ No, if yes, provide the name of the management company/individual:

Name	Address	City/State/Zip	Telephone No.
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You must complete the information below regarding the person(s) who has responsibility for the residence's financial operation.

Name	Address	City/State/Zip	Telephone No.
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**Complete the following information on each corporate office, director, individual owner, and partner. Attach additional pages if necessary.**

**If the applicant/owner is a corporation, complete items 1 thru 7 as applicable.**

1.

Corporate President	Mailing Address	City State Zip	Telephone #
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2.

Corporate Vice-President	Mailing Address	City State Zip	Telephone #
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3.

Corporate Secretary	Mailing Address	City State Zip	Telephone #
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4.

Corporate Treasurer	Mailing Address	City State Zip	Telephone #
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5.

Director	Mailing Address	City State Zip	Telephone #
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6.

Director	Mailing Address	City State Zip	Telephone #
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7.

Director	Mailing Address	City State Zip	Telephone #
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**If the applicant/owner is an individual(s), complete items 8 thru 11 as applicable.**

8.

Individual Owner	Mailing Address	City State Zip	Telephone #
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9.

Individual Owner	Mailing Address	City State Zip	Telephone #
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10.

Individual Owner	Mailing Address	City State Zip	Telephone #
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11.

Individual Owner	Mailing Address City State Zip	Telephone #
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**If the applicant/owner is a general or limited partnership, or other type of ownership, complete items 12 thru 14 as applicable.**

12.

Partner Other (specify): _____	Telephone #
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Mailing Address	City	State	Zip
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13.

Partner Other (specify): _____	Telephone #
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Mailing Address	City	State	Zip
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14.

Partner Other (specify): _____	Telephone #
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Mailing Address	City	State	Zip
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**Corporations Only:** Enter the name(s) and address (es) of each person having at least a 5% ownership interest in the corporation which owns the ALR business (attach an addendum to the application, if necessary). If no person owns at least 5% of the corporation, please enter not applicable.

Name	Address	City/State/Zip	Percent of Ownership
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List the name(s) of any facility or other entity licensed by the District of Columbia or another state to provide health or assisted living care with which the administrator or any person listed in this section has been affiliated through ownership or employment within the last 5 years. [**Attach additional sheets if necessary.**]

Name & Type of Facility/Entity:

Address: \_\_\_\_\_

Dates of Affiliation: \_\_\_\_\_ Employee? \_\_\_\_\_ Owner? \_\_\_\_\_

25% or greater ownership interest \_\_\_\_\_ Yes? \_\_\_\_\_ No?

If the facility or other entity closed or ceased to operate due to financial problems; had a receiver appointed; had its license denied, suspended or revoked; was subject to a moratorium on admissions; or had an injunctive proceeding initiated against it, please provide a detailed description and explanation of the occurrence. [**Attach additional sheets if necessary.**]

Adverse Action(s): \_\_\_\_\_ Yes? \_\_\_\_\_ No? If yes, description, explanation, and date(s) of occurrence

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Does any owner, partner/associate/firm member, officer, or director have at least a 5% ownership interest in any professional service, firm, association, partnership, or corporation providing goods, leases, or services to the facility? \_\_\_\_ Yes \_\_\_\_ No. If yes, list the name and address of the professional service, firm, association, partnership, or corporation. [**Attach additional sheets if necessary.**]

Name of Business: \_\_\_\_\_

Address: \_\_\_\_\_

Nature of Business Relationship: \_\_\_\_\_

Has the applicant been terminated, permanently suspended, or excluded from the Medicaid programs? \_\_\_\_\_ Yes \_\_\_\_\_ No. If yes, please provide a description and explanation

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Has any officer, partner/associate/firm member, director, or person owning at least 5% or more of the facility ever been convicted of any offense prohibited by section 435.04, F.S.? \_\_\_\_\_ Yes \_\_\_\_\_ No. If yes, please provide a description and explanation:

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List three references of whom the agency may inquire as to the owner's, administrator's, and financial officer's character, reputation, and financial responsibility.

Name Address City/State/Zip Telephone #

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## **F. ADMINISTRATOR'S INFORMATION**

### **Name**

What date did the above person begin employment with the facility as the administrator? \_\_\_\_\_

Does the administrator have a high school diploma or G.E.D.? \_\_\_\_\_ Yes \_\_\_\_\_ No

Has the ALR administrator served as a direct care provider or administrator for at least one of the past three years? \_\_\_\_\_ Yes \_\_\_\_\_ No

Will the administrator be serving as administrator of more than this ALR? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, provide the name of the other facilities. \_\_\_\_\_

Name of Facility: \_\_\_\_\_ License Number \_\_\_\_\_

Name of Facility: \_\_\_\_\_ License Number \_\_\_\_\_

## **G. NAMES OF OWNERS OF AT LEAST 5%**

If the applicant is a corporation, please enter the name for each officer, director, and person having at least a 5 percent or greater ownership interest; enter the name for each member of a firm, partnership, or association; enter the name for each individual owner, administrator, and person having responsibility for the facility's financial operation.

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

## **H. SURETY BOND**

Does the owner, administrator, staff, or any facility representative serve as representative payee or as power of attorney or will be handling resident funds through a trust fund for any resident?

\_\_\_\_\_ Yes \_\_\_\_\_ No. If yes, attach a copy of the surety bond or continuation bond.

Signature of

Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship of Applicant to the Assisted Living Residence: \_\_\_\_\_

**NOTE:** I understand that if I knowingly falsify this application, the Department of Health, Health Care Regulation and Licensing Administration, Intermediate Care Facilities Division (DOH/HCLRA/ICFD) will move to revoke the license for which I'm applying.